



Kelley Counseling
Kelley Counseling PLLC

1145 – D Executive Circle

Cary, NC 27511

919-249-5423

Financial Agreement

I _____ (parent/client), agree to pay the co-pay, deductibles, co-insurance, and any past-due balance that may occur on my/my child's account that are not covered by my/their insurance benefits. I will be expected to pay by check, cash, or credit card. I further understand that if I want Kelley Counseling PLLC to file claims with my/my child's insurance company, that I am responsible for providing accurate insurance information, verifying my/my child's benefits with the insurance company, and understanding the limits of my/my child's coverage.

I agree to get preauthorization if it is required by my/my child's insurance company. I understand that I am expected to notify Kelley Counseling PLLC of any changes in insurance coverage. I agree that I will be responsible for any services and charges that are not covered in my/my child's insurance plan. I understand that any checks returned to Kelley Counseling PLLC are subject to an additional fee up to \$25 to cover bank fees that are incurred.

Insurance/ Payment Authorization

In order to file your/your child's insurance for you/your child, please review the following items and check that you agree with each one"

- ___ I authorize the use of this form on all my/my child's insurance submissions and permit a copy to be used in place of the original.
- ___ I authorize release of information to all my/my child's insurance carriers.
- ___ I understand that I am responsible for my/child's bill and that any outstanding bills will be sent to the billing address I have provided.
- ___ I authorize Kelley Counseling PLLC to act as my/my child's agent in helping me/my child obtain payment from my/my child's insurance carriers.
- ___ I authorize payment directly to Kelley Counseling PLLC and hereby assign my right to reimbursement for the services rendered to this practice.

Print Client Name

Client Signature

Date

Signature of Parent/Legal Guardian

Date

Signature of Provider

Date